

Department Of Health  
Health Professions Quality Assurance Division  
Washington Board Of Osteopathic Medicine And Surgery  
Policy/Procedure

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### *INTRODUCTION*

There are widespread concerns among patients throughout the state about access to appropriate medical treatment, including opioid therapy, for addressing chronic intractable pain. Similarly, providers express apprehensions about challenges by state disciplinary authorities when prescribing opioid analgesics for indicated medical treatment when serving the legitimate medical needs of pain patients. The under treatment of chronic pain due to concerns about addiction and drug diversion affect the public health, safety, and welfare. There is a need for guidance which would: a) encourage appropriate treatment for pain management; b) reduce providers' fear of injudicious discipline; and c) protect the public from inappropriate prescribing practices and diversion.

### *PURPOSE STATEMENT*

The Secretary of the Department of Health recommends the uniform adoption, by appropriate state regulatory authorities, of the following guidelines when managing pain. It is not the intent of these guidelines to define complete standards or acceptable medical care in the treatment of pain patients. These guidelines are not intended to direct clinical practice parameters. It is the intent that providers will have confidence that these guidelines are the standard by which opioid usage is evaluated.

### *GUIDELINES FOR OPIOID USAGE*

#### **Acute Pain**

Opioids are useful for patients with acute pain such as surgery, burn, or trauma. The goal of such treatment is to provide adequate and timely pain management to the patient. Side effects of opioids that are difficult to treat may occur and must

be balanced against the benefits of pain relief. The provider should, for any patient who has a history of alcoholism or other drug addictions, carefully monitor medications and when available seek appropriate consultation.

### **Chronic Pain Associated with Cancer**

Chronic pain associated with cancer may often be successfully managed with opioids. If use of opioids is the primary analgesic strategy, adequate doses should be given frequently enough to keep the patient continuously comfortable. Addiction is rare in patients with cancer pain; tolerance and physical dependency are often unavoidable and should not interfere with opioid prescribing. Not all pain in patients with cancer is responsive to opioids; alternative strategies for managing the pain should also be made available.

### **Other Chronic Pain Conditions**

Opioid analgesics can be useful in the treatment of patients with intractable non-cancer pain especially, where efforts to remove the cause of pain or to treat it with other modalities have failed or were not fully successful. The pain of such patients may have a number of different etiologies and may require several modalities. In addition, the extent to which pain is associated with psychological, physical, and social impairment varies greatly. Therefore, the selection for a trial of opioid therapy should be based on a careful assessment of the pain as well as the impairment experienced by the patient. Continuation of opioid therapy should be based on the provider's evaluation of the results of treatment, including the degree of pain relief, changes in psychological, physical, and social functioning, and appropriate utilization of health services. Providers are encouraged to obtain consultation from providers who are knowledgeable in pain management.

### *DEFINITIONS*

1. **Addiction** - A disease process involving use of psychoactive substances wherein there is loss of control, compulsive use, and continued use despite adverse social, physical, psychological, or spiritual consequences.
2. **Physical Dependence** - A physiologic state of adaptation to a specific psychoactive substance characterized by the emergence of a withdrawal syndrome during abstinence, which may be relieved in total or in part by re-administration of the substance. Physical dependence is a normal physiological consequence of habitual use of many substances, not just opiates. It does not equate to substance abuse or addiction, but will be seen with addiction.
3. **Psychological Dependence** - A subjective sense of need for a specific substance, either for its positive effects or to avoid negative effects associated with its abstinence.

4. **Tolerance** - State in which an increased dosage of a psychoactive substance is needed to produce a desired effect.
5. **Withdrawal Syndrome** - The onset of a predictable constellation of signs and symptoms following the abrupt discontinuation of, or rapid decrease in, dosage of a substance.
6. **Acute Pain** - An essential biologic signal of the potential for or the extent of injury. It is usually short-lived and is associated with hyperactivity of the sympathetic nervous system; e.g. tachycardia, increased respiratory rate and blood pressure, diaphoresis, and papillary dilation. The concurrent affect is anxiety.
7. **Chronic Pain** - Pain persistent beyond expected healing time often cannot be ascribed to a specific injury. Chronic pain may not have a well-defined onset and by definition does not respond to treatment directed at its causes.
8. **Intractable Pain in a Non-Cancer Patient** - Pain in which the cause cannot be removed or otherwise treated and no relief or cure has been found after reasonable efforts.

#### *GUIDELINES FOR ASSESSMENT AND DOCUMENTATION IN NON-CANCER PAIN*

Alternative strategies for managing pain must be explored. If alternative strategies for managing the pain are unsuccessful, long term opioid therapy can be added. The goal is not merely to treat the symptoms of pain, but to devise pain management strategies which deal effectively with all aspects of the patient's pain syndrome, including psychological, physical, social, and work-related factors. Documentation in the patient's medical record should include:

1. **History and medical examination** - A complete physical examination and comprehensive medical history should be part of the active treatment record including, but not limited to, a review of past pain treatment outcomes and any history of addiction risks to establish a diagnosis and treatment plan.
2. **Diagnosis and medical indication** - A working diagnosis must be delineated, which includes the presence of a recognized medical indication for the use of any treatment or medication.
3. **Written treatment plan with recorded measurable objectives** - The plan should have clearly stated, measurable objectives, indication of further planned diagnostic evaluation, and alternative treatments.

4. **Informed consent** - Discussions of risks and benefits should be noted in some format in the patient's record. The use of a patient contract and informed consent is encouraged.
5. **Periodic reviews and modifications indicated** - At these periodic reviews, the provider should reassess the treatment plan, the patient's clinical course, and outcome goals with particular attention paid to disease progression, side effect and emergence of new conditions.
6. **Consultation** - The treating provider should be knowledgeable and competent in referring patients to the appropriate specialist if needed and noting in the patient's record the treating provider's interpretation of the consultation reports. Additionally, a new patient with evidence of at-risk patterns of opioid usage should be evaluated by a knowledgeable specialist.
7. **Records** - The provider should keep accurate and complete records documenting the dates and clinical findings for all evaluations, consultations, treatments, medications and patient instructions.
8. **Assessment and monitoring** - Some patients with chronic pain not associated with cancer may be at risk of developing increasing opioid consumption without objective improvement in functional status. Subjective reports by the patient should be supported by objective observations. Objective measures in the patient's condition are determined by an ongoing assessment of the patient's functional status, including the ability to engage in work or other gainful activities, patient consumption of health care resources, positive answers to specific questions about the pain intensity and its interference with activities of daily living, quality of family life and social activities, and physical activity of the patient as observed by the physician.

Physical dependence and tolerance are normal physiologic consequences of extended opioid therapy and are not the same as addiction. Addiction is a disease with behavior characterized by psychological dependence and aberrant drug related behaviors. Addicts compulsively use drugs for non-medical purposes despite harmful effects; a person who is addicted may also be physically dependent or tolerant. Patients with chronic pain should not be considered addicts merely because they are being treated with opioids.

The physician is responsible for monitoring the dosage of the opioid. Monitoring includes ongoing assessment of patient compliance with drug prescriptions and related treatment plans. Communication between health care providers is essential. The patient should receive long term analgesic medications from one physician and where possible one pharmacy. All

providers should exercise appropriate caution for any patient with a history of alcoholism or other drug addiction when prescribing long term opioids. Consults with additional physician(s) appropriate to management and treatment of the patient's pain and addiction are recommended.

### *PATIENT RESPONSIBILITIES*

1. It is the patient's responsibility to candidly provide the treatment provider with a complete and accurate treatment history, including past medical records, past pain treatment and alcohol and other drug addiction history.
2. The patient should participate as fully as possible in all treatment decisions.
3. The patient and family members, if available, should inform the prescriber of all drug side effects and concerns regarding prescription drugs.
4. The patient should not use other psychoactive agents, including alcohol, naturopathic products or over-the-counter drugs without agreement of the prescriber.
5. The patient should use the same name when receiving medical care to assure completeness of the medical record.
6. The patient should demand respect and expect to be believed.
7. The patient should keep an open mind and be willing to work with the treatment provider, including:
  - a. negotiate with the provider to arrive at an acceptable plan of treatment;
  - b. be open in trying alternative treatment strategies; and
  - c. follow the treatment provider's instructions precisely.
8. The patient should, where possible, get all central nervous system medications from one provider. If this is not possible, the patient should inform each provider of all medications he/she is receiving.
9. The patient should, where possible, have all prescriptions filled at a single pharmacy.
10. The patient should not hoard, share, or sell medications.
11. The patient should be aware that providers may, by law, share information with other providers about the patient's care.